



Malaria

County _____

Case name (last, first) _____
 Birth date ___/___/___ Sex at birth F M Other Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____
 LHJ Case ID (optional) _____
 LHJ notification date ___/___/___
 Classification Classification pending Confirmed
 Not reportable Probable Ruled out Suspect
 Investigation status
 In progress
 Complete
 Complete – not reportable to DOH
 Unable to complete Reason _____
 Investigation start date ___/___/___
 Investigation complete date ___/___/___
 Case complete date ___/___/___
 Outbreak related Yes No
 LHJ Cluster ID _____ Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ Years Months
 Ethnicity Hispanic or Latino Not Hispanic or Latino Unk
 Race (check all that apply) Unk Amer Ind/AK Native
 Asian Black/African Amer Native HI/other PI
 White Other _____
 Primary language _____
 Interpreter needed Yes No Unk
 Employed Yes No Unk Occupation _____
 Industry _____ Employer _____
 Work site _____ City _____
 Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College
 Graduate School Vocational Online Other
 School name _____
 School address _____
 City/State/County _____ Zip _____
 Phone number _____ Teacher's name _____

REPORT SOURCE

Initial report source _____
 LHJ _____
 Reporter organization _____
 Reporter name _____
 Reporter phone _____
 All reporting sources (list all that apply)

COMMUNICATIONS

Primary HCP name _____
 Phone _____
 OK to talk to patient (If Later, provide date)
 Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___
 Complete Partial Unable to reach
 Patient could not be interviewed
 Alternate contact Parent/Guardian Spouse/Partner
 Friend Other _____
 Name _____ Phone _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk

Clinical Features

Y N Unk

Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F
 Recurring fever
 Chills or rigors
 Sweats
 Malaria in past 12 months (prior to this report) Date of prior illness ___/___/___
 Prior species _____

Complications

Y N Unk

Acute respiratory distress syndrome (ARDS)
 Cerebral malaria
 Kidney (renal) abnormality or failure
 Anemia (Hb < 11, Hct < 33)
 Severe anemia (Hb < 7)
 Any other complication _____

Pregnancy

Pregnancy status at time of symptom onset

Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _____

OB name, phone, address _____

Outcome of pregnancy Still pregnant Fetal death (miscarriage or stillbirth) Abortion

Other _____

Delivered – full term Delivered – preemie Delivered – Unk

Delivery method Vaginal C-section Unk

Postpartum (Estimated) delivery date ___/___/___

OB name, phone, address _____

Outcome of pregnancy Fetal death (miscarriage or stillbirth) Abortion

Other _____

Delivered – full term Delivered – preemie Delivered – Unk

Delivery method Vaginal C-section Unk

Neither pregnant nor postpartum Unk

Clinical testing

% Parasitemia _____

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____

Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Still hospitalized As of ___/___/___

Y N Unk

Died of this illness Death date ___/___/___ Please fill in the death date information on the Person Screen

Autopsy performed

Death certificate lists disease as a cause of death or a significant contributing condition

Location of death Outside of hospital (e.g., home or in transit to the hospital) Emergency department (ED)

Inpatient ward ICU Other _____

RISK AND RESPONSE (Ask about exposures 7-30 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country _____

Does the case know anyone sharing travel with similar symptoms of illness

In last 12 months before symptom onset, blood transfusion or organ transplant Date ___/___/___

Reason _____

Exposure and Transmission Summary

Likely geographic region of exposure In Washington – county _____ Other state _____

Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Public Health Issues

Y N Unk

Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis Agency and location _____

Date ___/___/___ Specify type of donation _____

Public Health Interventions/Actions

Y N Unk

Notified blood or tissue bank (if recent donation)

TREATMENT

Y N Unk

Did patient receive prophylaxis/treatment

Specify Anti-malarial _____

Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___

Were all pills taken as prescribed Yes-missed no doses No-missed one to a few doses

No-missed more than a few but less than half of the doses No-missed half or more of the doses

No-missed doses but not sure how many Unk

Reason for missed doses Forgot Didn't think needed Had side effects (specify _____)

Advised by others to stop Prematurely stopped taking once home Unk

Other _____

NOTES**LAB RESULTS**Lab report information**Lab report reviewed – LHJ**

WDRS user-entered lab report note _____

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen**Specimen identifier/accession number** _____**Specimen collection date** ___/___/___ **Specimen received date** ___/___/___**WDRS specimen type** _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result**WDRS test performed** _____**WDRS test result, coded** _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed PendingTest result status Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date ___/___/___

Upload documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____